THE BOYS' BRIGADE AUSTRALIA
Form F - Epilepsy Management Plan

Ref: M-6
Last Update: 1/07

Contacts

Name		**Date of Birth**	
Parents / Caregivers Names	**Home Telephone**	**Work Telephone**	
Name of Doctor:		**Phone**	
Ambulance / Emergency Contact:			

Epilepsy History

Type of seizure/s experienced?			
How frequently do you experience seizures?			
Known triggers? (eg. weather, photosensitivity, diet, stress, etc.)			
Seizure pattern:			
Build up and onset	**The seizure**	**The period after the seizure**	
Regular Medication:			
Drug name	**Dose**	**Time Taken**	**Form of Administration**
Additional Information:			
Critical Response time: Some older groups may undertake activities involving a high level of physical activity in isolated locations where an emergency response time could exceed 2 hours. Is it safe for the participant to undertake such activities?			**Yes No n/a**

Emergency Action

Detailed plan of treatment provided by medical practitioner is attached ☐ If a doctor / specialist has provided authorisation for the administration of treatment in an emergency situation all details should be noted in the emergency action plan.	
Or; Standard Epilepsy emergency action plan as below should be followed.	
☐ **Step 1:**	Note the time and length of the seizure.
☐ **Step 2:**	Remain with the person. Move harmful objects away; put something soft under head and shoulders; do not put anything in mouth; loosen any tight clothing; do not restrain.
☐ **Step 3:**	As soon as possible roll the person onto side to assist breathing.
☐ **Step 4:**	After the seizure allow the person to rest until they have fully recovered. Reassure them until they are aware of their surroundings.
☐ **Step 5:**	If the seizure lasts more than 5 minutes, if another seizure quickly follows the first, or the person remains unconscious or is injured, call an ambulance.
In the event of a seizure, do you want details of that seizure to be recorded as per the attached form. Indicate (by ticking the boxes beside the numbers) the information to be recorded. ☐ **Yes** ☐ **No**	

I declare that the information on this form is complete and correct and is based on advice provided by a medical practitioner. I further request that the medication as specified on this form be administered, or assistance be provided in the management of the medication, in accordance with the instructions provided.

Signature: …… **Relationship to Person: ...**……

Print Name: …….. **Date:** ……/……/……

Record of Epileptic seizure

Name		Date of Birth	

☐ 1.	Date of the seizure	
☐ 2.	Exact time of the day	
☐ 3.	What was the person doing at the time?	
☐ 4.	Had the person just fallen asleep or woken up?	
☐ 5.	What called your attention to the seizure?	
☐ 6	Did the seizure progress slowly or quickly?	
☐ 7.	How long did each stage of the seizure last?	
☐ 8.	What parts of the body were affected?	
☐ 9.	Was one side affected more than the other?	
☐ 10.	Did the body become stiff?	
☐ 11.	Did it jerk, twitch or go into convulsions?	
☐ 12.	Was the person unconscious?	
☐ 13.	If not was there any alteration in awareness?	
☐ 14.	Did the skin show changes (flushed, clammy etc.)?	
☐ 15.	Did the breathing change?	
☐ 16.	Did the person talk or perform any actions during the seizure?	
☐ 17.	Was the person incontinent of bladder or bowel?	
☐ 18.	Did the person vomit?	
☐ 19.	Did any injuries result from the seizure?	
☐ 20.	How did the person behave after the seizure (alert, drowsy, confused)?	
☐ 21.	After recovery did the person remember any unusual sensations before or at the onset of the seizure?	
☐ 22.	How long did the person take to recover completely?	
☐ 23.	If the person takes medication, when was the last dose before the seizure?	
☐ 24.	Anything else associated with the seizure you think the doctor should know?	

Completed by:	